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No. 95-110

In the Supreme Court of the United States

OCTOBER TERM, 1995

RYE PSYCHIATRIC HOSPITAL CENTER, INC.,
PETITIONER

v.

DONNA E. SHALALA,
SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

Whether petitioner, a psychiatric hospital governed by a specific Medicare reimbursement system (TEFRA), is entitled to an adjustment for treating a large proportion of low-income patients, when the Medicare statute and implementing regulations expressly authorize that adjustment only for hospitals governed by a different Medicare reimbursement system (PPS).

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 3a-26a) is reported at 52 F.3d 1163. The opinion of the district court is reported at 846 F. Supp. 1170.[1]

JURISDICTION

The judgment of the court of appeals (Pet. App. 1a-2a) was entered on April 10, 1995. The petition for a

[1] The district court opinion reprinted in petitioner's appendix (Pet. App. 27a-41a) is not the decision in this case. It appears to have been included by mistake. We therefore cite the reported decision.

writ of certiorari was filed on July 10, 1995 (a Monday). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. Before 1982, the Medicare program reimbursed hospitals for providing inpatient services to eligible patients under a "reasonable cost" formula generally based on necessary costs actually incurred. 42 U.S.C. 1395x(v); see generally *Good Samaritan Hosp.* v. *Shalala*, 113 S. Ct. 2151, 2154-2155 (1993). In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act (TEFRA) to give hospitals an incentive to reduce their costs. Pub. L. No. 97-248, 96 Stat. 324. Under TEFRA, hospitals that keep their costs under a "target amount" are entitled to bonuses, and hospitals that exceed that amount must absorb at least some of the additional costs. 42 U.S.C. 1395ww(b)(1). The target amount under TEFRA is based on the "allowable operating costs" for inpatient services during a one-year base period, increased by an annual percentage. 42 U.S.C. 1395ww(b)(3)(A); 42 C.F.R. 413.40(b)(1). The statute provides for adjustments to that increase

> where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period.

42 U.S.C. 1395ww(b)(4)(A)(i).

In addition, under a 1990 amendment to TEFRA, hospitals may ask for additional relief, which the Secretary may provide "as [she] deems appropriate." 42 U.S.C. 1395ww(b)(4)(A)(i) (Supp. V 1993). Such

relief may include the adoption of a new base period "which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services." *Ibid.*; see 42 C.F.R. 413.40(i).

b. In 1983, Congress established the "prospective payment system" (PPS) to give hospitals incentives for increased efficiency and to give the government more control over health care expenditures. H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983). Under the PPS, payment to hospitals for most inpatient services is based on predetermined national or regional average rates for the cost of treating particular illnesses. See 42 U.S.C. 1395ww(d). Cases are classified into one of approximately 470 "Diagnosis Related Groups" (DRGs), and compensation is based on those classifications rather than the actual costs of each case. See 42 U.S.C. 1395ww(d). A 1986 amendment to the statute authorized additional adjustments to the reimbursement schedules for PPS hospitals serving a "significantly disproportionate number of low-income patients" with special needs (the disproportionate share adjustment, or DSA). 42 U.S.C. 1395ww(d)(5)(F); see also 42 C.F.R. 412.106.

The 1983 Act establishing the PPS specifically excluded five types of hospitals from that reimbursement system, including psychiatric hospitals such as petitioner. 42 U.S.C. 1395ww(d)(1)(B)(i). Psychiatric hospitals, including petitioner, continue to be reimbursed under TEFRA. See *Tucson Medical Center* v. *Sullivan*, 947 F.2d 971, 975 n.5 (D.C. Cir. 1991); see also *Good Samaritan*, 113 S. Ct. at 2155 n.3.

2. Petitioner brought this action to compel the Secretary to increase its reimbursement on the ground that it serves a disproportionately large share of low-income patients. 846 F. Supp. at 1176. It

argued that it was entitled to the additional reimbursement under 42 U.S.C. 1395ww(d)(5)(F), the provision that expressly authorizes DSAs for PPS hospitals, and that the denial of DSAs to non-PPS hospitals violated principles of substantive due process and equal protection. See 846 F. Supp. at 1177.

The district court granted summary judgment for petitioner on a ground not raised by either party. It agreed with the Secretary that Section 1395ww(d)(5)(F) applies only to PPS hospitals, and not to TEFRA hospitals such as petitioner. 846 F. Supp. at 1180. The court also held, however, that petitioner was entitled to a DSA under 42 U.S.C. 1395ww(b)(4)(A). The court determined that the first sentence of Section 1395ww(b)(4)(A) (reproduced at p. 2, *supra*) —which authorizes adjustments for TEFRA hospitals based on "extraordinary circumstances, including changes in the case mix of such hospital," 42 U.S.C. 1395ww(b)(4)(A)—"deals in different language with the same factual problem of a substantial proportion of low-income patients" as does Section 1395ww(d)(5)(F). 846 F. Supp. at 1183. The court based that determination on its view that the term "case mix" in Section 1395ww(b)(4)(A) "clearly includes the concept of 'significant[]ly] disproportionate number of low-income patients.'" 846 F. Supp. at 1183 (quoting Section 1395ww(d)(5)(F)). The court further determined (846 F. Supp. at 1183) that the adjustment sought by petitioner was also authorized by the second sentence of Section 1395ww(b)(4)(A), which empowers the Secretary to make such adjustments "as [she] deems appropriate." 42 U.S.C. 1395ww(b)(4)(A). The court issued its opinion as declaratory relief. 846 F. Supp. at 1184.

3. On cross-appeals, the court of appeals reversed the rulings in favor of petitioner and affirmed those in favor of the Secretary. Pet. App. 3a-26a.

The court of appeals held, first, that the district court properly interpreted Section 1395ww(d)(5)(F) to exclude psychiatric hospitals and other non-PPS hospitals from eligibility for DSAs. Pet. App. 14a-19a. The court observed that Section 1395ww(d)(5)(F) applies only to PPS hospitals, *i.e.*, "subsection (d) hospital[s]," a term defined to mean "other than * * * a psychiatric hospital." Pet. App. 14a-15a (quoting 42 U.S.C. 1395ww(d)(5)(F)(i) and 1395ww(d)(1)(B)).

The court of appeals held, next, that petitioner was not entitled to a DSA under 42 U.S.C. 1395ww(a)(2). Pet. App. 17a-18a. Section 1395ww(a)(2) provides in pertinent part:

> The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under (1)(A) as he deems appropriate, including those which he deems necessary to take into account—
>
> * * * * *
>
> (B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income * * *.

The court determined that Section 1395ww(a)(2) did not apply to the time periods for which petitioner sought additional reimbursement. The court explained that Section 1395ww(a)(2) "provide[d] for exceptions to the [cost] limitations established by [42 U.S.C.] 1395ww(a)(1)(A)," which, it pointed out, did

"not apply to reporting periods beginning after October 1, 1983." Pet. App. 18a (citing 42 U.S.C. 1395ww(a)(1)(D)). Accordingly, the court reasoned, the exception to those cost limitations provided by Section 1395ww(a)(2) likewise was inapplicable to reporting periods after October 1, 1983. Pet. App. 18a.

The court of appeals further held that additional reimbursement was not available under 42 U.S.C. 1395ww(b)(4)(A), the provision upon which the district court had relied. Pet. App. 19a-24a. The court of appeals concluded that the term "case mix" in subsection (b)(4)(A) "refers to the medical condition of a hospital's patients, not to their financial conditions." Pet. App. 20a. In support of that conclusion, the court cited the two provisions that it had already found to apply only to cost periods prior to October 1983. In connection with the general cost limitations established by Section 1395ww(a)(1)(A), the statute at that time had directed the Secretary to "establish case mix indexes for all short-term hospitals, and * * * set limits for each hospital based upon the general mix of types of medical cases." Pet. App. 20a (quoting 42 U.S.C. 1395ww(a)(1)(B)(i)). That provision, the court explained, made it "reasonably plain that 'case mix' refers to the mix of medical [conditions] rather than financial conditions of the patients." Pet. App. 20a. That reading was reinforced by the provision allowing the Secretary, in her discretion, to adjust or exempt a hospital from the general limitations in Section 1395ww(a)(1)(A) to accommodate "the special needs of * * * hospitals that serve a significantly disproportionate number of patients who have low income." Pet. App. 21a (quoting 42 U.S.C. 1395ww(a)(2)(B)). The court reasoned that the separate provision for hospitals

with a disproportionate number of low-income patients would have been unnecessary if the term "case mix" incorporated that factor, since "case mix indexes" were the basis for the general cost limitations that applied in the absence of an exemption or adjustment under the separate provision. Pet. App. 21a.

The court of appeals found further support for its interpretation of the term "case mix" in the differences between the PPS and the TEFRA reimbursement systems. Pet. App. 23a-24a. The court observed that the DSA authorized for PPS hospitals "is attributable to Congress's conclusion that low-income patients tend to be in poorer health, and therefore to cost more to treat, than others." *Id.* at 23a. Because PPS hospitals are reimbursed on the basis of DRGs that reflect national or regional average costs of treating various illnesses, "PPS hospitals that treat a disproportionate share of low-income patients * * * would be shortchanged * * * for doing so unless the per illness reimbursement were adjusted upward to take account of that fact." *Ibid.* In contrast, a TEFRA hospital is reimbursed "based on its allowable costs in a base year," which includes "any added costs associated with the treatment of low-income patients in the base year." *Ibid.* Thus, to the extent that those added costs are reflected in the base year, an adjustment providing additional compensation for those same costs could result in over-reimbursement. *Ibid.*[2]

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[2] The court of appeals also found support for its interpretation of "case mix" in the legislative history and in the Secretary's interpretation of the Medicare statute. Pet. App. 21a-23a. It observed that the term was used in the legislative

The court of appeals "recognize[d] * * * that a TEFRA hospital may incur added costs that are not included in its base, * * * particularly if the proportion of low-income patients served increases as compared with its base year." Pet. App. 24a. But the court observed that "a TEFRA hospital is not without recourse in these circumstances" (*ibid.*); it could apply for an adjustment under Section 1395ww(b)(4)(A). The court emphasized, however, that an adjustment under that provision "would be based on the fact that more of its patients are sicker or require more intensive or extensive care, not on their income levels." *Ibid.*

Finally, the court of appeals rejected petitioner's claim that, if the Medicare statute were construed to deny DSAs to TEFRA hospitals while authorizing them for PPS hospitals, it would violate equal protection. Pet. App. 24a-25a. To the extent that petitioner advanced that claim as a facial challenge, the court held that the differential treatment was reasonable in light of the differences between the two reimbursement systems. *Id.* at 25a. To the extent that petitioner sought to make the claim on an "as applied" basis, the court held that its challenge was not ripe because it had not applied for an adjustment under Section 1395ww(b)(4)(A). See Pet. App. 25a.

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history "in the context of indices of case mix complexity which, like the Yale University system which it specifically mentioned, dealt with medical condition." *Id.* at 21a. The court also observed that "[t]he Secretary repeatedly has construed the term 'case mix' to refer to the types of medical cases treated by hospitals." *Id.* at 22a.

ARGUMENT

The court of appeals correctly held that petitioner is not entitled to additional Medicare reimbursement based on its treatment of an allegedly disproportionate share of low-income patients.[3] Petitioner acknowledges (Pet. 10) that the decision below "is the only decision by an appellate court to consider the availability of the [disproportionate share adjustment] to non-PPS hospitals." Further review is therefore not warranted.

1. In the courts below, petitioner relied on three statutory provisions in claiming additional reimbursement. None of those provisions supports petitioner's claim.

a. Only one of the provisions cited by petitioner expressly mandates additional reimbursement to hospitals for treatment of a disproportionate share of low-income patients. That is 42 U.S.C. 1395ww(d)(5)(F)(i), which in relevant part states:

> For discharges occurring on or after May 1, 1986, and before October 1, 1995, the Secretary shall provide * * * for an additional payment amount for each subsection (d) hospital which—
>
> > (I) serves a significantly disproportionate number of low-income patients * * *.

As both courts below correctly held, Section 1395ww(d)(5)(F) does not apply to non-PPS hospitals such as petitioner. Pet. App. 14a-15a; 846 F. Supp. at 1180. Section 1395ww(d)(5)(F) applies only to PPS

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[3] The district court assumed, without deciding, that petitioner "treats a substantial number of low-income patients." 846 F. Supp. at 1180 n.35. For purposes of this brief, we assume the same.

hospitals, *i.e.*, "subsection (d) hospital[s]," a term that is defined to exclude psychiatric hospitals and other hospitals that continue to be reimbursed under the TEFRA provisions of Section 1395ww(b), rather than under the PPS. See 42 U.S.C. 1395ww(d)(1)(B)(i).

Petitioner does not directly challenge the conclusion of the courts below that only PPS hospitals are entitled to the disproportionate share adjustment (DSA) authorized by Section 1395ww(d)(5)(F). Instead, petitioner relies on two sets of statutory provisions that it contends form the "background" for Section 1395ww(d)(5)(F). Pet. 14. One set of provisions, which predates Section 1395ww(d)(5)(F), directed the Secretary to develop criteria for making DSAs to PPS hospitals. See Pet. 11 (citing Social Security Amendments of 1983 (1983 Act), Pub. L. No. 98-21, § 601(e), 97 Stat. 157) and Pet. 13 (citing Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2315(h), 98 Stat. 1080-1081). The other set of provisions directed the Secretary to study whether non-PPS hospitals could be brought into the PPS or a similar prospective reimbursement system. Pet. 6-7 (citing 1983 Act, § 603(a), 97 Stat. 166-167, and Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6003(i), 103 Stat. 2158). Those "background" provisions are irrelevant, for they do not alter the facts that Section 1395ww(d)(5)(F) limits DSAs to PPS hospitals and that petitioner is not a PPS hospital.

b. Petitioner renews (Pet. 18-21) its contention that it is entitled to a DSA under 42 U.S.C. 1395ww (a)(2). The courts below correctly held that Section 1395ww(a)(2) does not apply to the time periods for which petitioner sought reimbursement. Pet. App. 17a-18a; see 846 F. Supp. at 1173 n.6, 1178 n.30.

In Section 1395ww(a)(2), Congress authorized the Secretary to provide for "exemptions from, and exceptions and adjustments to," the general cost limitations established by Section 1395ww(a)(1)(A). 42 U.S.C. 1395ww(a)(2). Congress further provided that those limitations "shall not apply to cost reporting periods beginning on or after October 1, 1983." 42 U.S.C. 1395ww(a)(1)(D). As the court of appeals reasoned, because Section 1395ww(a)(2) exclusively concerns departures from the generally applicable cost limitations of Section 1395ww(a)(1)(A), it is operative only for those reporting periods for which the general limitations are operative: *i.e.*, periods before October 1983. Pet. App. 18a. Because the present case concerns later cost reporting periods (see 846 F. Supp. at 1177), Section 1395ww (a)(2) is inapplicable here.

Petitioner also argues that Section 1395ww(a)(2) must be construed to apply to later cost reporting periods for three reasons, none of which is persuasive. Petitioner argues, first, that Section 1395ww(a)(2) was so "vital" that, if Congress had intended it not to apply after October 1983, "this conclusion would be found in the legislative history." Pet. 19. "It is not the law," however, "that a statute can have no effects which are not explicitly mentioned in its legislative history." *Pittston Coal Group* v. *Sebben*, 488 U.S. 105, 115 (1988).[4] Petitioner also points out that, after

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[4] Accord, *e.g.*, *Eli Lilly & Co.* v. *Medtronic, Inc.*, 496 U.S. 661, 669 n.2 (1990); *Standefer* v. *United States*, 447 U.S. 10, 20 n.12 (1980); *Harrison* v. *PPG Industries, Inc.*, 446 U.S. 578, 592 (1980); see also *Morales* v. *Trans World Airlines, Inc.*, 504 U.S. 374, 385 n.2 (1992) ("[L]egislative history need not confirm the details of changes in the law effected by statutory language

October 1983, Congress enacted a technical amendment correcting a misspelling in Section 1395 ww(a)(2). Pet. 20. That amendment signifies that the provision had not been repealed, but it implies nothing about the cost reporting periods to which it was applicable. Finally, petitioner argues that Congress "reaffirmed" the continuing availability of a DSA under Section 1395ww(a)(2) when it amended 42 U.S.C. 1395f(b)(2) in 1984 to include a reference to hospitals that serve large numbers of low-income patients. Pet. 14; see also Pet. 8, 15, 23, 28. The district court, however, correctly held that the reasonable cost system set forth in Section 1395f(b) has been substantially modified by the TEFRA reimbursement provisions of Section 1395ww(b). 846 F. Supp. at 1178 (citing 42 U.S.C. 1395f(b) (payment is "subject to the provisions of sections 1395e and 1395ww of this title") and 42 U.S.C. 1395ww(b) (applies "[n]otwithstanding section 1395f(b) of this title")).

In any event, if we assume arguendo that Section 1395ww(a)(2) were applicable to the cost reporting periods at issue here, it still would not entitle petitioner to additional reimbursement for serving a disproportionate share of low-income patients. Section 1395ww(a)(2) provides in relevant part:

> The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account—

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before we will interpret that language according to its natural meaning.").

* * * * *

> (B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income * * *.

Contrary to petitioner's assertion, Section 1395ww (a)(2) is not "mandatory." Pet. 12. Rather, as the court of appeals held (Pet. App. 18a n.6), it gives the Secretary discretion to make only those adjustments and exceptions that she "deems appropriate" (42 U.S.C. 1395ww(a)(2)(B)). Compare *Webster* v. *Doe*, 486 U.S. 592, 600 (1988). Nor is Section 1395ww(a) (2)(B) a "specific DSA requirement * * * for psychiatric hospitals," as petitioner asserts (Pet. 12). Instead, it authorizes the Secretary to take into account the "special needs" of two categories of hospitals: (1) "psychiatric hospitals," and (2) "public or other hospitals that serve a disproportionate number of patients who have low income." See 47 Fed. Reg. 43,285 (1982). It does not imply a categorical determination that psychiatric hospitals serve large numbers of low-income patients, much less a categorical determination that they are entitled to additional compensation for doing so.

c. Finally, petitioner argues that it was entitled to additional compensation under 42 U.S.C. 1395ww(b) (4)(A), which in relevant part provides:

> The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix

> of such a hospital, create a distortion in the increase in costs for a cost reporting period.[5]

The court of appeals correctly upheld the Secretary's interpretation of this provision, under which the term "case mix" refers to the variety of medical conditions of a hospital's patients. See, *e.g.*, 47 Fed. Reg. 43,296, 43,303 (1982) ("case mix" involves consideration of the "number of possible combinations of diagnoses, procedures, complications, and admitting status"). As the court of appeals explained in detail, that interpretation accords with the language,[6] structure,[7] and legislative history[8] of the Medicare statute.[9]

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[5] The sentence immediately following that quoted in the text authorizes the Secretary to provide for such other exemptions, exceptions, and adjustments "as the Secretary deems appropriate." 42 U.S.C. 1395ww(b)(4)(A). Although the district court relied on that second sentence, as well as the first, in holding that petitioner was entitled to relief (see 846 F. Supp. at 1183), petitioner does not rely on it here; instead, petitioner relies only on the sentence of Section 1395ww(b)(4)(A) quoted in the text. In any event, the second sentence does not support petitioner's position.

[6] The Medicare statute directs the Secretary, for cost reporting periods prior to October 1983, to establish "case mix indexes" and to set cost limits for each short-term hospital "based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this subchapter." 42 U.S.C. 1395ww(a)(1)(B)(i). A separate provision authorizes the Secretary to depart from those limits as necessary to accommodate "the special needs of * * * hospitals that serve a significantly disproportionate number of patients who have low income." 42 U.S.C. 1395ww(a)(2)(B)). As the court of appeals reasoned, the two provisions make clear that Congress did not consider the term "case mix" to include the proportion of patients with low income. If Congress had intended "case mix" to reflect the financial condition of patients, the second

provision, authorizing departures from the case-mix-indexed limitations based on the number of low-income patients, would be superfluous in light of the first provision. See Pet. App. 20a; see also, *e.g.*, 42 U.S.C. 1395ww(d)(9)(B)(ii)(III)-(IV) (reimbursement formula for Puerto Rico uses terms "case mix" and "disproportionate share [of low-income patients]" in successive provisions).

[7] As the court of appeals explained, because a PPS hospital is reimbursed based on national or regional average costs for treating a particular illness, an adjustment may be appropriate to reflect the fact that an individual PPS hospital serves a disproportionate share of low-income patients, whose financial condition may make the same illness more costly to treat (see Pet. App. 5a). A TEFRA hospital, in contrast, is reimbursed on the basis of the allowable costs actually incurred in a base year. Thus, if a TEFRA hospital incurred higher allowable costs than other hospitals in its base year because it served a higher proportion of low-income patients, that fact will be taken into account without the need for a separate adjustment. *Id.* at 23a-24a. As the court recognized, the base year will not take into account any *change* in the proportion of low-income patients served by a TEFRA hospital, and such a change may result in an increase in allowable costs that are not adequately reflected by the annual percentage increases. In that situation, the hospital may apply for an adjustment under Section 1395ww (b)(4)(A), but the adjustment "would be based on the fact that more of its patients are sicker or require more intensive or extensive care, not on their income levels." Pet. App. 24a. Several courts have relied on the differences between the PPS and TEFRA systems in denying to PPS hospitals adjustments authorized by the TEFRA provisions. See, *e.g.*, *Hillsborough County Hosp. Auth.* v. *Shalala*, 49 F.3d 1516 (11th Cir. 1995), petition for cert. pending, No. 95-98; *Episcopal Hosp.* v. *Shalala*, 994 F.2d 879, 884 (D.C. Cir. 1993), cert. denied, 114 S. Ct. 876 (1994); *Sacred Heart Medical Center* v. *Sullivan*, 958 F.2d 537, 545-549 (3d Cir. 1992). Contrary to petitioner's argument (Pet. 18), those precedents support, rather than conflict with, the court of appeals' denial of a PPS adjustment to a TEFRA hospital in this case.

Petitioner asserts that, "if the adjustment for changes in case mix required by [Section 1395ww](b)(4)(A) is to have any meaning at all, it must include an adjustment for a hospital treating a large number of poorer, thus sicker patients." Pet. 26-27. As the court of appeals explained, however, Section 1395ww(b)(4)(A), as interpreted by the Secretary, provides meaningful relief. In accordance with that interpretation, a hospital may apply for an adjustment under Section 1395ww(b)(4)(A) based on a showing that, as compared to its base year, "more of its patients are sicker or require more intensive or extensive care." Pet. App. 24a.[10]

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[8] As the court of appeals observed (Pet. App. 21a-22a), the legislative history referred to "case mix" in the context of indices of medical complexity and expressly referred to a Yale University system that dealt with medical condition. S. Rep. No. 494, 97th Cong., 2d Sess. 24-25 (1982); H.R. Conf. Rep. No. 760, 97th Cong., 2d Sess. 418 (1982).

[9] Petitioner cites (Pet. 25-26) three decisions under another statute that it claims illustrate "variations" in the meaning of the term "case mix." Significantly, none of those decisions uses the term to refer to a patient's financial condition. See *Massachusetts Federation of Nursing Homes, Inc.* v. *Massachusetts*, 772 F. Supp. 31, 33 (D. Mass. 1991) (under Medicaid, " '[c]ase mix' refers to patients' levels' of sickness, or acuity"); see also *New Jersey Ass'n of Health Care Facilities, Inc.* v. *Gibbs*, 838 F. Supp. 881, 912 (D.N.J. 1993) (Medicaid); *Multicare Medical Center* v. *Washington*, 768 F. Supp. 1349, 1361-1362 & n.3 (W.D. Wash. 1991) (Medicaid).

[10] 42 C.F.R. 413.40(g)(3)(i) provides that the Secretary (through the Health Care Financing Administration (HCFA)) "may make an adjustment to take into account factors that would result in a significant distortion in the operating costs of inpatient hospital services between the base year and the cost reporting period subject to the [otherwise applicable reimbursement] limits." Among the factors upon which such

2. Petitioner appears (see Pet. 11, 30) to renew its contention that the denial of DSAs to non-PPS hospitals violates the equal protection component of the Due Process Clause. That contention does not merit further review.[11] Non-PPS hospitals are not a suspect class, and petitioner's claim of differential treatment does not implicate a fundamental right. The question is therefore whether Congress rationally could limit DSAs to PPS hospitals. See, *e.g.*, *Schweiker* v. *Wilson*, 450 U.S. 221, 234-236 (1981). For the reasons set forth in the decisions below, Congress rationally could do so. Pet. App. 24a-25a; 846 F. Supp. at 1181-1182.

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an adjustment may be based are "[i]ncreases in service intensity or length of stay attributable to changes in the type of patient served." 42 C.F.R. 413.40(g)(3)(ii)(D). Petitioner errs in suggesting (Pet. 23 n.13) that the service-intensity/length-of-stay factor is excluded from consideration by 42 C.F.R. 413.40(g)(3)(iii). The latter provision merely states that HCFA may make an adjustment based on certain factors "[w]ithout a formal request from a hospital." 42 C.F.R. 413.40(g)(3)(iii). As noted above, petitioner has never made such a request.

[11] It is doubtful that petitioner's equal protection claim is properly presented. The court of appeals observed that petitioner has not applied under Section 42 U.S.C. 1395ww(b)(4)(B) for the additional compensation that it sought in this action. Pet. App. 25a. The court correctly held that petitioner's failure to do so made its "as applied" equal protection challenge not ripe. *Ibid.* In our view, that failure also precludes consideration of any facial equal protection claim. A contrary conclusion would permit a facial constitutional challenge to a statute by a litigant to whom the statute has not been applied in the manner claimed to be unconstitutional.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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